DARREN W. LOVE, M.ED.
Therapy | Speaking | Coaching

Hamme & Associates
3454 Oak Alley Court, Suite 405
Toledo, Ohio 43606

phone
419.215.4567

fax
419.472.8675

Counseling Service Agreement:
Your Rights and My Policies

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign the Client Information & Consent for Treatment Form, it will represent that you understand your rights and agree with my policies.

COUNSELING SERVICES

Counseling is not easily described in general statements. It varies depending on the personalities of the counselor and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Counseling is not like a visit to your family doctor. Instead, it calls for a very active effort on your part. In order for the counseling to be most successful, you will have to work on things we talk about both during our sessions and at home.

Counseling can have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who go through it. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an assessment of your needs. By the end of the assessment, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with counseling. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Counseling involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

SESSIONS

During the time of initial assessment, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If counseling is begun, I will schedule one appointment hour of 50 minutes duration at a frequency and time we agree on, although some sessions may be longer or frequency may change. Once an appointment hour is scheduled, you will be expected to attend unless you provide 24 hours advance notice of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control. You will be expected to pay half the fee if you cancel less than 24 hours in advance and the full fee if you provide no notice of cancellation since insurance providers do not pay for missed sessions.

PROFESSIONAL FEES

My fee for the initial assessment is $185.00 and the hourly fee for individual counseling is $135.00. In addition to individual counseling appointments, I charge an hourly fee of $60.00 for other consultation services (includes report writing, phone conversations over 10 minutes, attendance at meetings you request me to attend, or other services you may request), though I will break down the hourly cost in 15-minute blocks for periods of less than one hour. As an established client, you may also take advantage of online support services as outlined on my website, darrenwlove.com. If you become involved in legal proceedings and require my participation, you will be expected to pay for my professional time. Because of the difficulty of legal involvement, I charge $175.00 per hour for preparation and attendance at any legal proceeding. The payment schedule for additional services is included in the intake packet.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held unless you have insurance coverage. If you have insurance coverage, I will accept the insurance reimbursement for covered services and will only expect co-pay fees, if any, to be paid at the time of service unless we agree otherwise. In circumstances of unusual financial hardship, I may be willing to negotiate a payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his or her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. For example, certain insurance providers may not allow some services and you will be expected to pay for all services not covered by your insurance plan. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

CONTACTING ME

I am sometimes not immediately available by telephone. I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail that I continually monitor. I will return your call on the same day. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or call Rescue Mental Health Services at 419.255.2801. If it is an emergency, call 911 or go to the nearest emergency room and ask for the

psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. These records are considered Protected Health Information. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted or may be upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Additional information regarding your Protected Health Information is included in the intake packet. Clients will be charged an appropriate fee for any time spent in preparing information requests.

CONFIDENTIALITY

In general, the law protects the privacy of all communications between a client and a counselor, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment unless you use your state of mental health as a defense. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he or she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I am required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to an identifiable person or persons, including an identifiable structure, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for a client. If a client threatens to harm himself or herself, I am obligated to seek hospitalization for him or her; or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case or will be under supervision with another provider because of insurance purposes. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant or supervisor is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations or supervision sessions unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

CHILD AND ADOLESCENT CONFIDENTALITY

Before treatment, it's important for you to understand my approach to child and adolescent counseling and agree to some rules about your child's confidentiality while in treatment. One risk of child counseling involves disagreements among parents or disagreements between parents and the counselor regarding the best interests of the child. If such

disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain mine. We can either resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether counseling will continue. If either of you decides that counseling should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

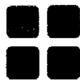
Counseling is most effective when a trusting relationship exists between the counselor and the client. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" so that they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence.

However, it's my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he or she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming himself or herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision.



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Client Information and Consent for Treatment Form

Client Name: ______________________

Address: ______________________
(Street) (City) (State & Zip Code)

Home Phone: __________ Cell: __________ Work: __________

Client SSN: __________ Client Date of Birth: __________

Martial Status: Married [ ] Single [ ] Spouse's Name: __________

Gender: Male [ ] Female [ ] Spouse's Work Phone: __________

Client's Employer: ______________________

Who is Financially Responsible for this Bill?

Name: ______________________

Address: ______________________
If different from clients (Street) (City) (State & Zip Code)

Home Phone: __________ Cell: __________ Work: __________

Insured SSN: __________ Insured Date of Birth: __________

Insured's Employer ______________________

Insurance Carrier: ______________________

Primary Care Physician: ______________________

Address: ______________________
(Street) (City) (State & Zip Code)

Current Medications: ______________________

____

Past Mental Health Outpatient Treatment: ______________________

____

Past Substance Abuse Outpatient Treatment: ______________________

____

Past Mental Health / Substance Abuse Inpatient Treatment: ______________________

(OVER)

Current Medical Conditions: ______________________________

____

____

Emergency Contact Person: ______________________________

Referral Source: ______________________________

Copy of Insurance Card(s) Attached: Yes [ ] No [ ]

I hereby give permission to Darren W. Love, M.Ed., LPCC-S or designee to provide counseling for me on an outpatient basis and by signing this form, I am acknowledging the following:

1. I have a right to an explanation of the risks and benefits for each proposed counseling service, of alternative treatments, and of no treatment.

2. I have the right to refuse treatment.

3. Darren W. Love, M.Ed., LPCC-S, or designee will be responsible for making efforts to develop alternative approaches to ensure that needed services are received.

4. Darren W. Love, M.Ed., LPCC-S, or designee will be responsible for explaining the implications and potential consequences of refusing or withdrawing consent for counseling.

5. I am in receipt of an explanation of my rights and the policies of the Counseling Service Agreement, Fee Schedule, and HIPAA Notice of Privacy Practices by Darren W. Love, M.Ed., LPCC-S or designee.

Ohio law requires that insurance reimbursable mental health services be provided by, or under supervision of, a licensed physician, psychologist, professional clinical counselor, professional counselor, or clinical nurse specialist whose nursing specialty is mental health (ORC 3923.28). In order to comply with the above law, when Larry E. Hamme, Ph.D. is the only approved provider for your insurance company, he will be responsible for said supervision and his name will appear on your insurance forms and bills. And, when Darren W. Love, M.Ed., LPCC-S is an approved provider for your insurance company, he will be responsible for said supervision and his name will appear on your insurance forms and bills.

I authorize insurance claims to be filed for me and also that information regarding counseling services rendered be furnished to the insurance company at their request.

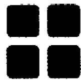
My signature below indicates that I have read the client information and policy statements in the Counseling Service Agreement and agree to abide by its terms during our professional relationship.

I understand that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered. Payment for service is due at the time of it's delivery. Appointments not cancelled within 24 hours of the appointment will be charged a no-call fee. You may contact Mr. Love at **419.215.4567** and he will contact you the same day, or use the office's 24-hour phone service at **419.472.7330** where messages can be left at any time.

Client Signature ______________________________ Date__________

Parent Signature (if applicable) ______________________________ Date__________

Witness Signature ______________________________ Date__________



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Client Fee Schedule

Service	Fee
Initial Diagnostic Assessment Session *(including medical record review and writing initial report)*	$185 this typically last 60+ minutes
Individual Counseling Session	$135 for 50 minute session
Individual Counseling Session *(that include assessment instruments and their interpretation)*	$175 this typically last 60+ minutes
Couple Counseling Session *(typically not covered by insurance companies)*	$135 for 50 minute session
Family Counseling Session *(including additional preparation and notation for multiple participants)*	$165 for 50 minute session
Group Counseling Sessions *(typically not covered by insurance companies)*	$50 per person for each session
Attendance At Any legal Proceeding *(including preparation, travel to and from court, and time spent at the legal proceeding)*	$175 per hour
Consultation *(including report writing, phone conversations over 10 minutes, attendance at meetings you request me to attend, or other services you may request)*	$60 per hour

All fees and co-pays are due upon delivery of services

Clients are responsible for reimbursement of fees. We have no way of knowing for certain if your insurance policy will reimburse services, but we will gladly file the insurance form for reimbursement.

I understand that I will pay half of the fee for an appointment not cancelled within 24 hours of the scheduled appointment and the full fee for an appointment for which I don't call to cancel and for which I don't show up. Insurance companies cannot be billed for missed appointments. I also understand that I am responsible for all services not covered by insurance.

My signature below indicates that I have read the Client Fee Schedule and agree to abide by its terms during our professional relationship.

Client Signature ____ Date__________

Parent Signature (if applicable) ________________________________ Date__________

Witness Signature ____ Date__________

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HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it.

This notice of privacy practices describes how we may disclose your Protected Health Information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your counselor, our office staff, and others outside of our office that are involved in your case and treatment for the purpose of providing mental health care services to you, to pay your behavioral health care bills, to support the operation of the counselor's practice, and any other use required by law.

Treatment
We will use and disclose your Protected Health Information to provide, coordinate, or manage your behavioral health care and any related services. This includes the coordination or management of your behavioral health care with a third party. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your Protected Health Information will be used as needed, to obtain payment for your behavioral health care services. for example, obtaining approval for a hospital stay may require that your relevant Protected Health Information be disclosed to the health plan to obtain approval for the hospital admission.

Behavioral Healthcare Operations
We may disclose, as needed, your Protected Health Information in order to support business activities of your counselor's practice. these activities include, but are not limited to, quality assessment activities, employee review activities, training of counselor trainees or clinical residents, licensing, and conducting or arranging for other business activities. For example, we may disclose your Protected Health Information to counseling students or residents that see clients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your counselor. We may also call you by name in the waiting room when your counselor is ready to see you. We may disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment.

We may use your Protected Health information in the following situations without your authorization. These situations include: As Required by Law, Public Health Issues as Required by Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates, and Required Uses and Disclosures Under the Law. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted And Required Uses And Disclosures
We will make other disclosures only with your consent, authorization, or opportunity to object unless required by law.

(Over)

You May Revoke This Authorization
You may revoke your authorization at any time, in writing, except to the extent that your counselor or the counselor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You Have The Right To Inspect And Copy Your Protected Health Information
Under federal law, however, you my not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to Protected Health Information.

You Have The Right To Request A Restriction Of Your Protected Health Information
This means you may ask us not to disclose any part of your Protected health Information for the purposes of treatment, payment, or behavioral healthcare operations. You may also request that any part of your Protected Health Information not be disclosed to family members or friends who may be involved in your case or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction apply.

Your counselor is not required to agree to a restriction that you may request. If the counselor believes it is in your best interest to permit use and disclosure your Protected Health Information, your Protected Health Information will not be restricted. You then have the right to use another healthcare professional.

Your Have The Right To Request To Receive Confidential Communications From Us By Alternative Means Or At An Alternative Location.

You Have The Right To Obtain A Paper Copy Of This Notice From Us
Upon request, even after you have agreed to accept this notice by alternative means (i.e. electronically).

You Have The Right To Receive An Accounting Of Certain Disclosures We Have Made, If Any, Of Your Protected Health Information

Filing A Grievance
You may file a grievance with us if you believe we have violated your privacy rights. You may file a grievance with us by notifying our privacy contact, Melanie Hanus, of your grievance.

We Will Not Retaliate Against You For Filing A Grievance

This notice was published and becomes effective on or before **April 14, 2003**.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number at 419. 472.7330.

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print Name ____ Date___________

Client Signature ____ Date___________

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Internet, Email, and Wireless Device Usage for Non-Counseling Activities Agreement: Your Rights and My Policies

What you can expect:

You can choose to communicate with me for non-counseling reasons by using Internet, Email, or wireless devices such as a cell phone, laptop computer, iPad, or smart phone (iPhone, Android, etc.). This may include talking, leaving voice mail messages, texting, sending or receiving email, use of live chat services, or live video chat services.

I will use reasonable means to protect the security and confidentiality of Internet, Email, and wireless device communications sent and received. However, because of the risks identified below, I can't guarantee the security of Internet, Email, or wireless device communication, and am not liable for improper disclosure of confidential information that is not caused by my intentional misuse.

Risk of using the Internet, Email, and wireless devices to communicate:

Transmitting confidential information to me as well as receiving confidential information from me has a number of risks that you need to consider.

- Internet, Email, and wireless communications can be intercepted, circulated, forwarded and stored in numerous paper and electronic files, or used without authorization or detection.
- Internet, Email, and wireless device communication can be immediately broadcast worldwide and be received by unintended recipients and is easier to falsify than handwritten or signed documents.
- Email senders can easily type in the wrong email address.
- Back-up copies or transmissions may exist even after the sender or the recipient has deleted his or her copy.
- Internet, Email, and wireless device service providers and their employees have the right to archive and inspect communications transmitted through their systems.
- Internet, Email, and wireless device communication can be used to introduce viruses or other destructive elements into computer systems or wireless devices.
- Internet, Email and wireless device communications can be used in court.

Client obligations when using Internet, Email, and wireless device communications for general information:

- Use Internet, Email, and wireless device communications only for general client information. not for medical emergencies or to engage in counseling.
- When using Internet communications like Email only include your first name and last initial in the body of the message. Include a phone number where you can be reached.
- Follow-up with me if you have not received a response to your Email or text message within 24 hours.
- Use screen savers and safeguard your computer or wireless device with a password.
- Withdraw consent of Internet, Email and wireless device communications through written communication.

Alternate forms of communication:

I understand that I may also communicate with the counselor via landline telephone or in person and that Internet, Email, and wireless device communications may not be a substitute for the care provided during an office visit. In-office appointments should be considered before discussing any new issues as well as any sensitive information. (OVER)

Types of non-clinical Internet, Email, and wireless device communication activities that you agree to send or receive:

The types of information that can be communicated via the Internet, Email, and wireless device services include **appointment scheduling requests, Email appointment reminders, billing and insurance questions, and client education**. As counselor, I will not engage in Internet, Email, or wireless device communications for counseling unless you, the client have signed the Online Therapy Support Agreement. As counselor I will not engage in counseling with clients that reside outside the state of Ohio. If you are unsure if an issue you wish to discuss should be included in an Internet, Email, or wireless device communication, you should call me to schedule an appointment.

Hold harmless clause:

I agree to indemnify and hold harmless the counselor, the therapy practice, its officers, website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet, Email, or wireless devices to communicate with the counselor or the use of his websites or blogs, any arraignments I make based on information obtained by the counselor's websites or blogs, any products or services obtained through the counselor's websites or blogs, and any breach by me of these restrictions and conditions. The counselor does not warrant that the functions contained in any materials provided will be uninterrupted or error-free, that defects will be corrected, or that the counselor's websites, blogs, or servers that make such sites available is free of viruses or other harmful components.

Termination of the Internet, Email, and wireless device communication relationship:

The counselor shall have the right to immediately terminate the Internet, Email, or wireless device communication relationship with the client if the counselor determines, in his or her sole discretion, that the client has violated the terms and conditions set forth above or otherwise breached this agreement, or has engaged in conduct which the counselor determines, in his or her sole discretion, to be unacceptable. The Internet, Email and wireless device communication relationship between the counselor and the client will terminate in the event that the counselor, in his or her sole discretion, no longer wishes to utilize the Internet, Email, or wireless devices to communicate with all of his or her clients.

Forwarding of Internet, Email, or wireless device communications:

I understand that there may be times in which the counselor must forward the information I have provided via Internet, Email, or wireless device communication to a third party for treatment, billing, and payment purposes. I expressly provide my consent to the counselor to forward these Internet, Email, and wireless device communications to a third party under these conditions and evidence my consent by placing my initials below:

______________________ (please initial if you agree)

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the counselor and acknowledge that I have read and fully understand this consent form. I understand the risks associated with Internet, Email, and wireless device communications between the counselor and myself, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the counselor may impose to communicate with clients via Internet, Email, or wireless devices. Any questions I may have had were answered.

Client Signature ______________________________________ Date__________

Witness Signature ______________________________________ Date__________

Client Email address:

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General Health and Mental Health Information

Date ________________

Client Name ________________ Age ________________

Date of Birth ________________ Gender Male [ ] Female [ ]

Children (please list ages) ________________

____

Date of last physical exam ________________

List medical problems for which you are being treated ________________

____

____

____

Medications you are currently taking ________________

____

____

Allergies to medication ________________

____

____

Other allergies ________________

____

Any major medical events (including pregnancies and surgeries) ________________

____

____

____

(Over)